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**BEFORE THE**
**BOARD OF REGISTERED NURSING**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**JUDY YVONNE WHITE, a.k.a.**<br>**JUDY YVONNE GROSS**<br>2058 Pasado Avenue<br>Manteca, CA 95336<br><br>Registered Nurse License No. 418904<br><br>Respondent. | Case No. 2010-163<br><br>**ACCUSATION** |

Complainant alleges:

**PARTIES**

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1987, the Board of Registered Nursing issued Registered Nurse License Number 418904 to Judy Yvonne White (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein, and expired on April 30, 2007, and has not been renewed.

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## JURISDICTION AND STATUTORY PROVISIONS

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws.

4. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse . . . for any of the following:
>
> (a) Unprofessional conduct.

8. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

9. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for herself.

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10. Health and Safety Code section 11173 provides, in pertinent part:

(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

(b) No person shall make a false statement in any prescription, order, report, or record, required by this division.

**DRUGS**

11. **Marijuana** is a Schedule I controlled substance as designated in Health and Safety Code section 11054, subdivision (d)(13).

12. **Morphine/Morphine Sulfate** is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

13. **Vicodin** is a trade name for **Hydrocodone** and is a Schedule III controlled substance as designated in Health and Safety Code section 11056, subdivision (e)(4).

**COST RECOVERY**

14. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

**FIRST CAUSE FOR DISCIPLINE**

(False, Grossly Incorrect, Grossly Inconsistent, or Unintelligible Entries in Hospital, Patient or Other Records)

15. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that on or about and between February 5, 2006, and March 28, 2006, while employed by Mark One Corporation, and on duty as a Registered Nurse at Bel Air Lodge Convalescent Home, Turlock, California, and Ha'Le Aloha Convalescent Hospital, Ceres, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible

entries in hospital, patient or other records pertaining to the controlled substances Vicodin and Morphine/Morphine Sulfate (MS), as follows:

**Patient A:**

a. On March 17, 2006, Respondent withdrew one Vicodin tablet at 1200 hours and one Vicodin tablet at 1400 hours from the Hospital's Controlled Drug Accountability Record (CDAR) under the name of Patient A. Respondent charted the administration of one Vicodin tablet at 1200 hours in the patient's Medication Administration Record (MAR) but failed to chart the administration of one Vicodin tablet in the patient's MAR. Respondent failed to chart the administration of the two Vicodin tablets or otherwise account for the administration, disposition, or waste of the tablets in the nurses progress notes or nurses medication notes for the patient.

b. On March 21, 2006, Respondent withdrew one Vicodin tablet at 1200 hours and two Vicodin tablets at 1700 hours from the Hospital's CDAR under the name of Patient A. Respondent charted the administration of one Vicodin tablet at 1200 hours and one Vicodin tablet at 1800 hours in the patient's MAR but failed to chart the administration, disposition, or waste of one Vicodin tablet in the MAR. Respondent failed to chart or otherwise account for the administration, disposition, or waste of three Vicodin tablets in the nurses progress notes or nurses medication notes for the patient.

c. On March 24, 2006, Respondent withdrew one Vicodin tablet at 0800 hours and one Vicodin tablet at 1200 hours from the Hospital's CDAR under the name of Patient A. Respondent failed to chart the administration of two Vicodin tablets on the patient's MAR and failed to chart the administration of two Vicodin tablets in the nurses progress notes or the nurses medication notes for the patient.

**Patient B:**

d. On March 7, 2006, Respondent withdrew one Vicodin tablet at 0800 hours, two Vicodin tablets at 1200 hours and one Vicodin tablet at 1600 hours from the Hospital's CDAR under the name of Patient B. Respondent charted the administration of one Vicodin tablet at 0800 hours, one Vicodin tablet at 1200 hours and one Vicodin tablet at 1600 hours in Patient B's MAR but failed to chart the administration of one Vicodin tablet in Patient B's MAR. Respondent failed to chart the administration of the four Vicodin tablets in the patient's care

record and to otherwise account for the administration, disposition, or waste of the Vicodin tablets.

e. On March 23, 2006, Respondent withdrew two *cc* of MS at 0700 hours, 1000 hours, 1200 hours, and 1400 hours from the Hospital's Liquid Drug Report under the name of Patient B. Respondent charted the administration of 2 *mg* of MS at 0700, 1000 hours, 1200 hours, and 1400 hours in the nurses medication notes for the patient. Respondent charted the administration of 2 *mg* of MS at 0700 hours in the nurses progress notes for the patient but failed to chart the administration of six *cc* of MS in said notes.

f. On March 24, 2006, Respondent withdrew four *cc* of MS at 0800 hours, 1000 hours, 1200 hours, and 1400 hours from the Hospital's Liquid Drug Report under the name of Patient B. Respondent charted the administration of four *mg* of MS at 0800 hours, 1000 hours, 1200 hours, and 1345 hours in the nurses medication notes for the patient. Respondent charted the administration of four *mg* of MS at 0800 hours and four *mg* of MS at 1000 hours in the nurses progress notes for the patient but failed to account for the administration, disposition, or waste of eight *cc* of MS in said notes.

g. On March 25, 2006, Respondent withdrew four *cc* of MS at 0730 hours, 0930 hours, 1130 hours, and 1330 hours from the Hospital's Liquid Drug Report under the name of Patient B. Respondent charted the administration of four *mg* of MS at 0730 hours, 0930 hours, 1130 hours, and 1330 in the nurses medication notes for the patient. Respondent charted the administration of four *mg* of MS at 0700 and four *mg* of MS at 1330 in the nurses progress notes for the patient but failed to account for the administration, disposition, or waste of eight *cc* of MS in said notes.

**Patient C:**

h. On March 23, 2006, Respondent withdrew one Vicodin tablet at 0700 hours and two Vicodin tablets at 1200 hours from the Hospital's CDAR under the name of Patient C.

Respondent charted the administration of one Vicodin tablet at 0700 hours and one Vicodin tablet at 1200 hours in the nurses medication notes for the patient but otherwise failed to account for the administration, disposition, or waste of one Vicodin tablet in the Hospital or nurses progress notes for the patient.

i. On March 24, 2006, Respondent withdrew one Vicodin tablet at 0800 hours from the Hospital's CDAR under the name of Patient C. Respondent charted the administration of one Vicodin tablet within the period of "7-3" on the patient's MAR but otherwise failed to chart the administration of one Vicodin tablet on the nurses progress notes for the patient.

j. On March 25, 2006, Respondent withdrew one Vicodin tablet at 0700 hours and one tablet at 1200 hours from the Hospital's CDAR under the name of Patient C. Respondent charted the administration of one Vicodin tablet at 0700 hours and one Vicodin tablet an 1200 hours on the nurses medication notes for the Respondent. Respondent charted the administration of one Vicodin tablet at a non-specific time within the period of "7-3" and one Vicodin tablet at a non-specific time within the period of "3-11" on the patient's MAR but otherwise failed to chart the administration of either of the two Vicodin tablets on the nurses progress notes for the patient.

k. On March 28, 2006, Respondent withdrew one Vicodin tablet at 1000 hours from the Hospital's CDAR under the name of Patient C. Respondent charted the administration of one Vicodin tablet at 1000 hours on the nurse medication notes for Respondent. Respondent charted the administration of one Vicodin tablet at a non-specific time within the period of "7-3" on the patient's MAR but otherwise failed to chart the administration of one Vicodin tablet on the nurse progress notes for the patient.

**Patient D:**

l. On February 3, 2006, Respondent withdrew two Vicodin tablets at 1400 hours from the Hospital's CDAR under the name of Patient D. Respondent charted the administration of Vicodin at a non-specific time within the period of "7-3" and Vicodin tablet at a non-specific time within the period of "3-11" in the patient's MAR but failed to chart the number of Vicodin

tablets administered. Respondent charted the administration of two Vicodin tablets at 0730 hours and two Vicodin tablets at 1400 hours in the nurses medication notes for the patient but failed to chart or otherwise account for the administration, disposition, or waste of four Vicodin tablets in the nurses notes for the patient.

m. On February 4, 2006, Respondent withdrew two Vicodin tablets at 0700 hours, two Vicodin tablets at 1100 hours, and two Vicodin tablets at 1500 hours from the Hospital's CDAR under the name of Patient D. Respondent charted the administration of Vicodin at a non-specific time within the period of "7-3" and at a non-specific time within the period of "3-11" in the patient's MAR but failed to chart the number of Vicodin tablets administered. Respondent charted the administration of two Vicodin tablets at 0700, two Vicodin tablets at 1100, and two Vicodin tablets at 1500 hours in the nurses medication notes for the patient but failed to chart or otherwise account for the administration, disposition, or waste of any of the Vicodin tablets in the nurses notes for the patient.

n. On February 5, 2006, Respondent withdrew two Vicodin tablets at 0900 hours and two Vicodin tablets at 1300 hours from the Hospital's CDAR under the name of Patient D. Respondent charted the administration of Vicodin at a non-specific time within the period of "7-3" and at a non-specific time within the period of "3-11" in the patient's MAR but failed to chart the number of Vicodin tablets administered. Respondent charted the administration of two Vicodin tablets at 0900 and two Vicodin tablets at 1300 in the nurse medication notes for the patient but failed to chart or otherwise account for the administration, disposition, or waste of any of the Vicodin tablets in the nurses notes for the patient.

o. On February 10, 2006, Respondent withdrew two Vicodin tablets at 0700 hours and two Vicodin tablets at 1400 hours from the Hospital's CDAR under the name of Patient D. Respondent charted the administration of Vicodin at a non-specific time within the period of "7-3" and at a non-specific time within the period of "3-11" in the patient's MAR but failed to chart the number of Vicodin tablets administered. Respondent charted the administration of two Vicodin tablets at 0700 hours and two Vicodin tablets at 1400 hours in the nurses medication

notes but failed to chart or otherwise account for the administration, disposition, or waste of any of the Vicodin tablets in the nurses notes for the patient.

**SECOND CAUSE FOR DISCIPLINE**

(Obtained, Possessed, Self-Administered Controlled Substances)

16. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that during the period of February 3, 2006, and October 28, 2008, Respondent obtained or possessed, or administered to herself the controlled substances Marijuana and Vicodin, a follows:

a. On or about and between February 3, 2006, and March 28, 2006, Respondent obtained the controlled substance Vicodin while employed by Mark One Corporation and on duty as a Registered Nurse at Bel Air Lodge Convalescent Home, Turlock, California, and Ha'Le Aloha Convalescent Hospital, Ceres, California.

b. On or about June 10, 2007, October 10, 2008, and October 26, 2008, Respondent self-administered the controlled substance Marijuana, in violation of Health and Safety Code section 11170.

c. On or about October 28, 2008, Respondent possessed the controlled substance Marijuana, in violation of Health and Safety Code section 11170.

**THIRD CAUSE FOR DISCIPLINE**

(Obtain or Attempt to Obtain Controlled Substances by Fraud, Deceit, Misrepresentation, Subterfuge or Concealment of a Material Fact)

17. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct and in violation of Health and Safety Code section 11173, subdivision (a), in that she obtained or attempted to obtain, procured or attempted to procure the administration of controlled substances by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of a material fact as set forth in paragraphs 15 and 16, above.

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## FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

18. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as set forth in paragraphs 15, 16, and 17, above.

## PRAYER

**WHEREFORE,** Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 418904, issued to Judy Yvonne White, a.k.a. Judy Yvonne Gross;

2. Ordering Judy Yvonne White, a.k.a. Judy Yvonne Gross to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/15/09

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
*Complainant*

SA2008305996